

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-016624**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **383** Primary Registration District No. **5655** Registrar's No. **247**

**FILED APR 24 1963**

1. PLACE OF DEATH a. COUNTY <b>LAWRENCE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MT. VERNON</b>		Length of stay in 1b <b>45 days</b>	c. CITY OR TOWN <b>UNION</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MISSOURI STATE SANATORIUM</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE 2</b>
3. NAME OF DECEASED (Type or print) <b>SYDNEY F. COTTAM</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1963</b>	

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-78</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANDIZING</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>RICHARD COTTAM</b>	13b. MOTHER'S MAIDEN NAME <b>EUNICE COTTAM</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Spanish Am. War</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>Medical Records, Mo. S.S. Mt. Vernon</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT, PROBABLY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PULMONARY TUBERCULOSIS, MODERATELY ADVANCED</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY. Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **MARCH 2, 1963** to **APRIL 11, 1963** and last saw him alive on **APRIL 15, 1963**  
Death occurred at **3:00 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>H. Vernon Langille, M.D.</i> (Degree or title)	22b. ADDRESS <b>MO. S.S. MT. VERNON, MO.</b>	22c. DATE SIGNED <b>4-15-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-15-63</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>
23d. LOCATION (City, town, or county) <b>Union Mo.</b>		23e. STATE

24. FUNERAL DIRECTOR <b>Oltmann Funeral Home</b>	25. DATE REC'D BY LOCAL REG. <b>4-16-63</b>	26. REGISTRAR'S SIGNATURE <i>Roy Dunham, Jr.</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

**0550**

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**9332XA**

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**135-0**

APR 25 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address MT Vernon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.